Committees: Homelessness and Rough Sleeping Sub-Committee	**Dated:** 26/04/2023
Subject: Daniel Safeguarding Adults Review	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	NA
Does this proposal require extra revenue and/or capital spending?	**No**
If so, how much?	**£ NA**
What is the source of Funding?	**NA**
Has this Funding Source been agreed with the Chamberlain's Department?	**NA**
Report of: Clare Chamberlain Interim Executive Director of Community and Children's Services	**For Information**
Report author: Chris Pelham Assistant Director People	

Summary

The Daniel Discretionary Safeguarding Adults Review (SAR) report was presented to the Homeless and Rough Sleeping Sub-Committee in November 2022. Oversight of the implementation of the report's recommendations is the responsibility of the City and Hackney Safeguarding Adults Board SAR Sub Group. The SAR Sub Group met on 19 April 2023 to review the current status of the recommendations' implementation.

It was agreed that updates on the implementation of the recommendations would be shared with Members of the Sub Committee. Due to the publication of the papers for the Sub Committee, and the SAR Sub Group having only recently just met, a verbal update will be provided at this Sub Committee on the progress of the implementation of the recommendations. The headlines and recommendations from the Discretionary SAR are included here for reference.

Recommendations

Members are asked to note that a verbal update will be provided on the implementation of the recommendations – as set out in the following report.

Main Report

Background

1. Daniel was classed as a '205' rough sleeper, meaning that he was considered to be an entrenched rough sleeper. He has been intermittently homeless for over 20 years, first coming to notice in Barnet in July 2001. Daniel had been living almost

exclusively in the City of London and was well known to rough sleeping and outreach services in the area.

2. On 15 April 2020, Daniel was admitted to St Thomas' Hospital by a member of staff at St Mungo's after expressing that he was going to take his own life. He was assessed by a doctor and reported that his ideation was caused by his inability to make money over lockdown, feeling like he was being taken advantage of, and missing his family. Due to a dispute regarding where Daniel should be placed for inpatient care, a decision was made to discharge him into hotel accommodation with on-going support to be provided by the South London and Maudsley Hospital NHS Foundation Trust Home Treatment team.

3. Following Daniel's discharge from hospital, he had some initial contact with mental health services, however, this engagement quickly declined. On 22 April 2020, professionals were informed that Daniel had left the hotel. On 8 May 2020, Daniel was arrested for being drunk and disorderly. He received a Community Protection Notice, banning him from the City of London for three months. Regardless of this, a suitable hotel was found for Daniel but attempts to engage him proved unsuccessful and there was a period of time where Daniel had not engaged with any services. On 26 May 2020 he was found on Millennium Bridge having made an attempt to end his own life. He was admitted to Royal London Hospital but sadly passed away four days later.

4. The review explored the following key lines of enquiry:
   - How well services in the City of London work together to tackle multi-exclusionary homelessness
   - How well services worked together to support Daniel
   - Whether agencies sufficiently identified and responded to Daniel's vulnerabilities
   - How well services in the City of London understand the intersections between substance misuse, anti-social behaviour and vulnerability
   - The intersection between homelessness and suicide
   - Any other safeguarding issues identified as a result of the review.

Recommendations

5. In total there were 13 recommendations made in respect of the review:

   i. Health (physical and mental) and social care services within the City of London should review how the concept of localisation is embedded within their service areas, particularly in relation to rough sleepers.
   ii. The City of London Corporation should undertake a 'temperature check' and engage with rough sleepers to assess how accessible key health and care services (ie. primary care, mental health, housing, substance misuse) are for them.
   iii. There should be a review of the following:
      a. Level of communications from the police to partner agencies, such as the street outreach team regarding rough sleepers

b. The active and continuing engagement of police with these services
c. How to use anti-social behaviour legislation in a way that helps to address issues rather than merely moving someone on to another geographical patch. There will be different ways to achieve such outcomes. For example, these could include a requirement to consider engagement with local services rather than being moved away from them
d. Community Protection Notice decision-making and involvement of other agencies (in this case it seems to have been unilaterally decided by police rather than being the outcome of a discussion with all the agencies involved)
e. Wider consideration of the range of possible interventions that could be options for more appropriate court disposals. (These would include Alcohol Treatment Requirements and Mental Health Treatment Requirements. Such provisions aim to help the individual to manage their behaviour and so to reduce offending.)

iv. The City of London Corporation should audit how well multi-agency meetings with rough sleepers are working and check that the correct people are being referred to these meetings.
v. Management within the mental health trust should examine the options for outreach staff to provide consultancy input to the trust or direct clinical input in cases involving rough sleepers. At present, there has been a specialist rough sleepers team within the East London Mental Health Foundation Trust, the Rough Sleeping and Mental Health Programme (RAMHP), although its future has not been decided; this might be a good place to embed this process.
vi. Daniel's case should be discussed at a weekly academic meeting at the Maudsley Hospital, which generally attracts a substantial audience of junior doctors.
vii. Both South London and Maudsley NHS Trust and the City and Hackney Safeguarding Adults Board should provide feedback on the problems outlined above and escalate to NHS England and NHS Improvement the concerns about the London Compact.
viii. Professionals working with people in the City should ensure that all residents being discharged from mental health services are referred to their GP post-discharge. Where an individual does not have a GP, they should be supported to register with a GP.
ix. SLAM and East London Foundation Trust should look at the principles of the Psychologically Informed Environment where the input of clinical psychologists is built into the normal functioning of the project.
x. All partners in the City of London should ensure that professionals working with rough sleepers are aware of and trained in strengths-based and trauma-informed approaches to safeguarding.
xi. Health and social care teams based in the City should assure themselves that multi-agency risk assessments are in place where residents are discharged from mental health services into temporary accommodation.

xii. A protocol should be put in place in the City where people who are rough sleeping go missing. This should include a checklist of when cases should be escalated to senior management or the police.

xiii. Both health and social care professionals working in the City of London should put in place regular (as agreed by the service user) check-ins for residents known to have significant concerns around suicidal ideation. These check-ins should remain in place until professionals are satisfied that the individual's suicidal ideation has been risk assessed and managed.

6. A verbal update will be provided at the Sub-Committee on the current status of the implementation of the recommendations.

Corporate & Strategic Implications

7. Strategic implications – None

8. Financial implications – None

9. Resource implications – None

10. Legal implications – Safeguarding Adults Reviews are a statutory duty under the Care Act 2014.

11. Risk implications – None

12. Equalities implications – The report takes equality issues into account throughout.

13. Climate implications – None

14. Security implications – None

Appendices

- Appendix 1 – Daniel SAR Report

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